



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PERTERSON REGIONAL MEDICAL CENTER
551 HILL COUNTRY DRIVE
KERRVILLE, TX 78028

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-0738-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above mentioned claim was denied for time limit for filing has expired. This claim was sent through P2P link it arrived at P2P on 5/27/10. I have enclosed proof of timely filing."

Amount in Dispute: \$644.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor argues it timely submitted the bill to its electronic agent, P2P, who, it alleges, submitted the bill timely to Texas Mutual...The document...that was attached with the requestor's bill nowhere substantiates that the document was electronically received by Texas Mutual's electronic vendor, Jopari. Please note, Texas Mutual does not have electronic connectivity with P2P. Further, when a bill is received from an electronic vendor that has connectivity with Texas Mutual's electronic vendor, Jopari, the upper right hand corner of the bill has the electronic vendors name and date printed on the bill. The bill that Texas Mutual received came through the USPS."

Response Submitted by: Texas Mutual Insurance Company 6210 E. Hwy 290 Austin Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2010	Outpatient Hospital Services	\$644.20	\$ 644.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for health care providers required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §133.403
5. 28 Texas Administrative Code §102.4 sets out the rules for non-commission Communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 9, 2010 and October 13, 2010

- CAC-29 THE TIME LIMIT FOR FILING HAS EXPIRED
- 731 PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05
- CAC-W4 NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 891 NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely and in accordance with Texas Labor Code, §408.027 and Texas Administrative Code §133.10 and §102.4.
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272 (b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the documentation submitted finds that the requestor did not meet the exceptions indicated in Texas Labor Code §408.0272 (b), (c) or (d). Therefore, the requestor was, in this case, required to submit the medical bill no later than 95 days after the service in dispute was provided.
2. Texas Administrative Code §102.4(h) states that "unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the documentation submitted, such as the medical bills, explanation of benefits and the requestor's electronic bill submission vendor notes/reports, finds convincing proof that the provider submitted the medical bill for the services in dispute in compliance with 28 Texas Administrative Code §133.20(b).
3. The division concludes that the medical bills for the services in dispute were submitted timely. For that reason, reimbursement be recommended.
4. Because no contract exists, reimbursement for the services in dispute is established under 28 Tex. Admin. Code §134.403 (f) which states "The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied..." Therefore,

the division must first determine the Medicare OPPS payment, and then apply the minimal modifications required by §134.403 (f) in order to establish the MAR.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. APCs are based on the services that appear on the hospital bill, the codes used, and the supporting documentation. A payment rate is established for each APC. A full list of APC's are published in the OPPS final rules each year which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website.
- CPT code 73610 is listed under APC 0260. The payment rate for APC 0260 is listed in OPPS Addendum A as \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of \$24.01. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts yields an APC payment amount of \$41.97. This service has a status indicator of X, which indicates ancillary services paid under OPPS with separate APC payment. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$41.97. This amount multiplied by 200% yields a MAR of \$83.94.
 - CPT code 99283 is listed under APC 0614. The payment rate for APC 0614 is listed in OPPS Addendum A as \$140.18. This amount multiplied by 60% yields an unadjusted labor-related amount of \$84.11. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of \$74.97. The non-labor related portion is 40% of the APC rate or \$56.07. The sum of the labor and non-labor related amounts yields an APC payment amount of \$131.04. This service has a status indicator of V, which indicates clinic or emergency department visit paid under OPPS with separate APC payment. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$131.04. This amount multiplied by 200% yields a MAR of \$262.07.
 - CPT code 29515 is listed under APC 0058. The payment rate for APC 0058 is listed in OPPS Addendum A as \$71.03. This amount multiplied by 60% yields an unadjusted labor-related amount of \$42.62. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of \$37.99. The non-labor related portion is 40% of the APC rate or \$28.41. The sum of the labor and non-labor related amounts yields an APC payment amount of \$66.40. This service has a status indicator of S, which indicates a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$66.40. This amount multiplied by 200% yields a MAR of \$132.79.
 - HCPCS code J3010 has a status indicator of N, which indicates packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - HCPCS code L4370 has a status indicator of A, which indicates services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.203(d)(1), the MAR for this service is 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. The DMEPOS fee for L4370 Pneumatic full leg splint is \$159.83. This amount multiplied by 125% yields a MAR of \$199.79.

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$644.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$644.20 reimbursement for the disputed services.

Authorized Signature

_____	_____	January 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.